MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03674

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Spa Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 50 Spa Road

3. NAME OF DECEASED: (Type or Print) (First) Clearence (Middle) (Last) Allen

4. DATE OF DEATH: (Month) 4 (Day) 27 (Year) 1953

5. SEX: male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: 10-1-1906 | 9. AGE last birthday: 46 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Contractor | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Will Allen | 14. MOTHER'S MAIDEN NAME: Susie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: 217-14-1846 | 17. INFORMANT & ADDRESS: Father Jones - Balto. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X

Immediate cause (a) Pulmonary Tuberculosis — Interval Between Onset And Death: 1 mon.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/27, 1953, to 4/27, 1953, that I last saw the deceased alive on 4/27, 1953, and that death occurred at 11:10 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Theodore L. Johnson M.D. ADDRESS 40 Maryland Ave Annapolis Md DATE SIGNED 4/30/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 5-1-53 | NAME OF CEMETERY OR CREMATORY Carpenter Hill | LOCATION (City, town, or county) (State) Jones-Round Bay Md.

DATE REC'D BY LOCAL REGISTRAR May 1, 1953 | REGISTRAR'S SIGNATURE J. E. O'Donnell

24. FUNERAL DIRECTOR William Deese ADDRESS 108 N. Washington St. Annapolis, Md.

VS A45

RECEIVED
MAY 4 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03675

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,

STREET ADDRESS (If rural, give location): 63 South River Rd.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): GEORGE WILLIAM ASQUITH

4. DATE OF DEATH: (Month) (Day) (Year): APRIL 23, 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	May 27, 1895	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret County Employee	Labore	Lothian, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James Asquith	Sallie Brady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes — WW I	none	Mrs. Elizabeth Asquith, Wife same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Infarcts, Multiple	3 wks ?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Pulmonary Artery Thrombosis	3 wks.
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 2 April 19 53, to 23 Apr. 19 53, that I last saw the deceased alive on 23 Apr. 19 53, and that death occurred at 8:12 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Edward L Beck M. D. 25 April 53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 27, 53	National Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
April 27, 1953	J. C. O'Donnell (D.W.)	Ben L. Hopping and Son Annapolis, Md.

RECEIVED
APR 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03676

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY: Anne arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md.
LENGTH OF STAY (in this place): 16 yrs. 19 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): 1010 Madison Avenue

3. NAME OF DECEASED: (Type or Print) (First) Marie (Middle) (Last) Booth

4. DATE OF DEATH: (Month) 4 (Day) 27 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: 1900?

9. AGE last birthday: 53? yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Music Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Coatley

14. MOTHER'S MAIDEN NAME: Tilley Harper

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk.
(If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY No.: — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

443X

Immediate cause (a) Hypertensive Cardiovascular Disease — Known to us for 1 year

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — — —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1, 19 53 to 4/27, 19 53 that I last saw the deceased alive on 4/27, 19 53 and that death occurred at 8:50 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold N. Eichert M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 4/27/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4/28/53
NAME OF CEMETERY OR CREMATORY: University Med. School
LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE REC'D BY LOCAL REGISTRAR: 4/28/53
REGISTRAR'S SIGNATURE: L. J. D'Alba
24. FUNERAL DIRECTOR: Frances A. Kemsley
ADDRESS: 578 N. Eddel St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 30 1953
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS. A1

MARYLAND STATE DEPARTMENT OF HEALTH

03677

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Jct.
LENGTH OF STAY (In this place) 82 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Jct.
STREET ADDRESS ✓ (If rural, give location)

3. NAME OF DECEASED (Type or Print): First John (Middle) (Last) Bowie Sr
4. DATE OF DEATH: Month ~~March~~ April (Day) 4 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Jan 20-1871
9. AGE last birthday: 82 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Annapolis Junction
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas John Bowie
14. MOTHER'S MAIDEN NAME: Susanne Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Henry B. Bowie Laurel, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Haemorrhage — Interval between onset and death: 3 days

443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vas. Disease — 1 yr.

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While at Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/14/52, to 4/4/53, that I last saw the deceased alive on 3/19/53, and that death occurred at 5 AM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank Shipley, M.D. Savage, Md. 5/6/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: April 7 1953 | NAME OF CEMETERY OR CREMATORY: Baldwyn Methodist Cem. | LOCATION (City, town, or county) (State): Millersville, Maryland

DATE REC'D BY LOCAL REG.: Apr 7-1953 | REGISTRAR'S SIGNATURE: Clara M. Lashley | 24. FUNERAL DIRECTOR: De Witt Donaldson, Laurel, Md | ADDRESS

RECEIVED
MAY 5 1953
BUREAU M.I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 013678

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 5 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE New Jersey — COUNTY Burlington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beverly
STREET ADDRESS (If rural give location) 32 Riverbank

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Lees (Last) BRAND

4. DATE OF DEATH: (Month) April (Day) 18, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 11-11-87

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: Rear Admiral, USN

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lewis Brand

14. MOTHER'S MAIDEN NAME: Annie Elisia Butt

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I & II

16. SOCIAL SECURITY NO.: 578-42-4715

17. INFORMANT & ADDRESS: Hospital Rceords, USNH, Annapolis, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
420.1 Immediate cause	(a) Myocardial Infarction # 420.1	2 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Coronary artery thrombosis #420.1	2 days
	DUE TO (c) Coronary Sclerosis #450	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diffuse Adenomatous goiter #251

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 13 April, 1953, to 18 April, 1953, that I last saw the deceased alive on 18 April, 1953, and that death occurred at 11:15 AM, from the causes and on the date stated above.

R.K. MOXON, LCDR, MC, USN. (Degree or title) — U.S. Naval Hospital, Annapolis, Md. (ADDRESS) — DATE SIGNED 4-18-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4-21-53 — NAME OF CEMETERY OR CREMATORY Naval Cemetery — LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REGISTRAR April 21, 1953 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR Ben L. Hopping and Son — ADDRESS Annapolis, Md.

VS. 15

RECEIVED
APR 22 1953
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Kent
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Millington
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) (Last) Brooks

4. DATE OF DEATH: (Month) 4 (Day) 7 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 8/24/1887

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months 7 Days 14 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Made AX handles

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Brooks

14. MOTHER'S MAIDEN NAME: Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY No.: 213-14-1966

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Generalized Arteriosclerosis — Interval Between Onset And Death: known to us

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Myocarditis Chronica — since admission

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 19 53 to 4/7, 19 53 that I last saw the deceased alive on 4/7, 19 53, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arnold H. Eichert M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 4/7/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Apr 11 1953 — NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemty — LOCATION (City, town, or county): Pondtown (State): Md.

DATE REC'D BY LOCAL REGISTRAR: 4-14-53 — REGISTRAR'S SIGNATURE: K M Jones

24. FUNERAL DIRECTOR: Edward Fellows — ADDRESS: Millington, Md.

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [redacted]380

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 25 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hosp. Crownsville

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Fredrick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fredrick
STREET ADDRESS (If rural give location) 161 All Saints St

3. NAME OF DECEASED: (Type or Print) (First) [redacted] (Middle) Ann (Last) Brown

4. DATE OF DEATH: (Month) April (Day) 25 (Year) 1953

5. SEX: Fe

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: ?

9. AGE last birthday: 75? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No Information

14. MOTHER'S MAIDEN NAME:

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) Generalized arteriosclerosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: Since admission MAR 31

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR 31, 1953, to April 25, 1953, that I last saw the deceased alive on Apr 25, 1953 and that death occurred at 10:35 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichel M.D. ADDRESS Crownsville. DATE SIGNED 4-25-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4/28/1953 NAME OF CEMETERY OR CREMATORY Fairview Cemetery LOCATION (City, town, or county) Fredrick, Md. (State)

DATE REC'D BY LOCAL REGISTRAR April 27, 1953 REGISTRAR'S SIGNATURE K. M. [illegible]

24. FUNERAL DIRECTOR Charles E. Hicks ADDRESS 24 W. All Saint St Fredrick, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 T

RECEIVED
MAY 5 1953
BUREAU V. P.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 97 Pri. Geo. St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 97 Pri. Geo. St.

3. NAME OF DECEASED: (Type or Print) (First) KATHERINE (Middle) E. (Last) BROWN

4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1953

5. SEX: Fem. | 6. COLOR OR RACE: White | 7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~, (Specify): | 8. DATE OF BIRTH: Mar 19, 1877 | 9. AGE last birthday: 76 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Travis P. Brown

14. MOTHER'S MAIDEN NAME: Katherine Burgess

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: T. Roland Brown Annapolis Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) Coronary Thrombosis	Several years
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arterio Sclerosis	Several years
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chr Arthritis Multiple	Several years

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 19 52, to April 11, 1953, that I last saw the deceased alive on April 11, 1953, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE George C Bond (Degree or title) M.D ADDRESS Annapolis Md DATE SIGNED 4-13-53

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | DATE THEREOF Apr. 14, 1953 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR April 14, 1953 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH:
COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 201 Annapolis St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 201 Annapolis St.

3. NAME OF DECEASED: (Type or Print) (First) Louise (Middle) M. (Last) Brown

4. DATE OF DEATH: (Month) 4 (Day) 28 (Year) 1953

5. SEX: F. 6. COLOR OR RACE: W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow 8. DATE OF BIRTH: June 26th 1864 9. AGE last birthday: 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House wife 10b. KIND OF BUSINESS OR INDUSTRY: Home 11. BIRTHPLACE (State or foreign country): Germany 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: — 17. INFORMANT & ADDRESS: Mrs May Fogle — 201 Annapolis St. Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Chr. with myocardial DUE TO — Interval Between Onset And Death: Several

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Senility DUE TO — Several years
(c) Generalized Arteriosclerosis — Several years

422.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1953, to April 28, 1953, that I last saw the deceased alive on April 28, 1953, and that death occurred at 2.30 PM from the causes and on the date stated above.

SIGNATURE George C Brent (Degree or title) M.D ADDRESS Annapolis Md DATE SIGNED 4.28.53

23. BURIAL, CREMATION, REMOVAL? (Specify) DATE THEREOF May 2 1953 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR April 29, 1953 REGISTRAR'S SIGNATURE RW

24. FUNERAL DIRECTOR John M. Layla Sons ADDRESS Annapolis Md.

APR
BUREAU V.

Item 21 Film G153 4-20-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

03683

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
STREET ADDRESS (If rural, give location) 4220 Audrey Avenue

3. NAME OF DECEASED (Type or Print): (First) Wm. (Middle) Byer (Last) BROWN
4. DATE OF DEATH (Month) Apr. (Day) 7 (Year) 19 53

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: July 18, 1921
9. AGE last birthday: 31 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Linoleum Layer
10b. KIND OF BUSINESS OR INDUSTRY: Floor craftsmen
11. BIRTHPLACE (State or foreign country): Damascus, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Brown
14. MOTHER'S MAIDEN NAME: Margaret Ann Muegrove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 218-18-0083
17. INFORMANT AND ADDRESS: Mrs. Margaret A. Brown, 4220 Audrey Ave. Brooklyn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4713. Immediate cause (a) Carbon monoxide asphyxia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) Jacobsville (COUNTY) An. Ar. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 4-7-53 12.05 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Carbon monoxide poisoning connected rubber hose to exhaust pipe of auto

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐, suicide X, homicide ☐, undetermined ☐.*

SIGNATURE: R S Fisher (Degree or title): MD ADDRESS: 700 Fleet St DATE SIGNED: April 7, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4/10/53
NAME OF CEMETERY OR CREMATORY: U.S. National Cemetery
LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: 4/9/53
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: Wm. Cole Inc.
ADDRESS: 1217 St. Paul St

Dec.!

Item 18 Film G154 6-4-53 SM

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1133 Gilmor St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ISIAH	(MATTHEWS)	COOPER	April	2	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Single	Aug. 14, 1936	16 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Cooper
14. MOTHER'S MAIDEN NAME: Ruth Tibbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Mrs. Ruth Cooper, 1133 Gilmor St.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

473 X

Immediate cause (a) Cerebral edema due to syncope during post-

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) operative period after T. and A. under pertothal anesthesia

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental deficiency

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Hospital
(CITY OR TOWN) (COUNTY) (STATE): Crownsville State Hosp. Anne Arundel, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 4-2-53 4:55 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Collapsed 15 minutes after tonsilectomy.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: R.B. Fisher — (Degree or title): MD — ADDRESS: Office of Chief Medical Examiner — DATE SIGNED: April 6, '53.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	4-9-53	Mt. Auburn	Balto City	Md.

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/6/53	W.W. Hubard	Wm. A. Jackson	916 Penna. Ave.

Dupl.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
STREET ADDRESS (If rural give location) 1401 Poplar Ave

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) F. (Last) Curran
4. DATE OF DEATH: (Month) 4 (Day) 27 (Year) 19 53

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-21-1883
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Plbg. Inspector A.A.Co
10b. KIND OF BUSINESS OR INDUSTRY: Plumber
11. BIRTHPLACE (State or foreign country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs Lillie M. Curran 1401 Poplar Ave Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Coronary occlusion — 1/2 h

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Gen arteriosclerosis & hypertension — 10 yr
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar ..., 19 45, to Apr 27, 1953, that I last saw the deceased alive on Apr 26, 1953, and that death occurred at 7:25 am 4/27/53, from the causes and on the date stated above.

SIGNATURE (Degree or title) S Bommelli M.D — ADDRESS Annapolis Md — DATE SIGNED 4/29/53

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — DATE THEREOF 4-29-53 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR April 29, 1953 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR John W. Taylor & Son — ADDRESS Annapolis Md

VS. A 5 (T)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]6

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George g Meade
LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Iowa — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedar Rapids
STREET ADDRESS (If rural give location) 402 Dunreath Drive, N.E.

3. NAME OF DECEASED: (Type or Print) (First) Ann (Middle) Skeen (Last) Doherty

4. DATE OF DEATH: (Month) 22 April (Day) (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant

8. DATE OF BIRTH: 21 April 1953

9. AGE Last birthday: yrs. — IF UNDER 1 YEAR: Months 1 + Days — IF UNDER 24 HRS.: Hours 26 Min. 17

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald R. Doherty

14. MOTHER'S MAIDEN NAME: Kathleen Hanson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Donald R Doherty, Officers Student Det. Fort Holabird, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

760.0 Immediate cause — (a) Congenital defects

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO 1. Pulmonary hemorrhage & atelectasis; 2. Bilateral

(b) tear of tentorium cerebelli with minimal hemorrhage;

DUE TO 3. Bilateral clubfeet

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 21 Apr. ,1953 , to 22 April , 1953 , that I last saw the deceased alive on 22 April , 1953 , and that death occurred at 0950 am , from the causes and on the date stated above.

SIGNATURE (Degree or title) WILLIAM TENENBLATT Capt MC (MD) — ADDRESS Ft Geo G Meade, Md. — DATE SIGNED 22 April 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 23 April 53 — NAME OF CEMETERY OR CREMATORY Post Cemetary — LOCATION (City, town, or county) (State) Fort George G Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 22 April 1953 — REGISTRAR'S SIGNATURE ARTHUR J GOFROSH Capt MSC

24. FUNERAL DIRECTOR HIRAM W. TROSTLE Capt (Chaplain) — ADDRESS Ft Meade,

2043263403

VS. 15 T

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arun
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) West Street Extd

3. NAME OF DECEASED: (Type or Print) (First) ISAAC (Middle) (Last) FINKELSTEIN

4. DATE OF DEATH: (Month) MRRIL (Day) 2, (Year) 53 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Nov. 3, 1877

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Ret Prop

10b. KIND OF BUSINESS OR INDUSTRY: General Store

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Finkelstein

14. MOTHER'S MAIDEN NAME: Rachiel Tabak

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) nO (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mr Milton Finkelstein Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Coronary Thrombosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerosis Heart Disease

DUE TO

(c) Generalized Arteriosclerosis

Interval Between Onset And Death

(a) Short time

(b) Long time

(c) Long time

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1953, to 4-2, 1953, that I last saw the deceased alive on 4-2, 1953 and that death occurred at ..... 9 A.M., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 4-2-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4-5-53 NAME OF CEMETERY OR CREMATORY Keneseth Israel Cemet LOCATION (City, town, or county) Annapolis, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR April 3, 1953 REGISTRAR'S SIGNATURE [signature] D.U.

24. FUNERAL DIRECTOR ADDRESS Ben L. Hopping and Son Annapolis, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03688 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY IN INK. Every item of information should be carefully supplied. The correct age is especially important: please write the names of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY

1. NAME OF DECEASED (Type or Print) Walker W Flanagan

2. DATE OF DEATH 4.8.1953

3. PLACE OF DEATH:
A. Baltimore City, Maryland Marley Neck RD
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marley Neck R.D.
c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Marley neck R D
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenburnie
D. STREET ADDRESS (If rural, give location) Marley Neck R. D.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	Col	married	June-3-01	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter
10B. KIND OF BUSINESS OR INDUSTRY Private
11. BIRTHPLACE (State or foreign country) Anne Arundel Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Flanagan
14. MOTHER'S MAIDEN NAME Mary Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Carol Flanagan ADDRESS Marley Neck R.D.

CAUSE OF DEATH

18. 442X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.

DUE TO

(B) Hypertensive Cardio renal vascular Disease. — 7 yrs.

DUE TO

(C) Essential Hypertension — 7 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

IFICATION

22. *I hereby certify that I attended the deceased from* 9.17. , 1952 *to* 4.8 , 1953 *that I last saw the deceased alive on* 4.8. , 1953 *and that death occurred at* 4:00 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE James M. Fair M. D.
23B. ADDRESS 400 N. Caroline Ave
23C. DATE SIGNED 4.10.1953

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-11-53	Mt Calvary and	Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1100 Bunting

VS 150
4-14-53

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS AA Gen Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 5 Colonial Ave

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Virginia (Last) Fowler

4. DATE OF DEATH: (Month) April (Day) 16 (Year) 19 53

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 9-14-878

9. AGE last birthday: 74 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: David V Miller

14. MOTHER'S MAIDEN NAME: Jennie J Dutton

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) —
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Colon C Fowler Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1
Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: Sudden

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Generalized Arteriosclerosis — Unknown
(156.1) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Liver — Unknown

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1953, to April 16, 1953, that I last saw the deceased alive on April 16 1953, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE George C Bisk (Degree or title) M.D ADDRESS Annapolis Md DATE SIGNED 4-17-53

23. BURIAL, CREMATION, REMOVAL— (Specify) — DATE THEREOF 4-20-53 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR April 19, 1953 — REGISTRAR'S SIGNATURE [illegible] — **24. FUNERAL DIRECTOR** Colon M Fowler & Son — ADDRESS Annapolis, Md

RECEIVED
APR 21 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03690

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
   COUNTY: Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena (Rural)
   LENGTH OF STAY (in this place): 62 years
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 6 Box 392

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland — COUNTY: Anne Arundel
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena (Rural)
   STREET ADDRESS (If rural give location): Route 6 - Box #392

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) H. (Last) Hahn

4. DATE OF DEATH: (Month) April (Day) 3, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: January 15 1867

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework (ret)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Hoffman

14. MOTHER'S MAIDEN NAME: Anna (Unknown)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Anna Sharp - Pasadena P.O. - Rt 6 Box 392

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Sclerosis — Interval Between Onset And Death: + 3 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Senility — + 3 years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1950, to April 3, 1953, that I last saw the deceased alive on 4/2/53 19 , and that death occurred at 3:40 P.M., from the causes and on the date stated above.

SIGNATURE: Constant A. Parker M.D. (Degree or title) ADDRESS: Glen Burnie Md DATE SIGNED: 4/3/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 6 1953 — NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — LOCATION (City, town, or county) (State): Brooklyn R.F.D.

DATE REC'D BY LOCAL REGISTRAR: April 4 1953 — REGISTRAR'S SIGNATURE: L. J. D'Alba

24. FUNERAL DIRECTOR: P F Singleton — ADDRESS: Glen Burnie, Md

RECEIVED
APR 6 1953
BUREAU V. S.

Item 9 FilmG153 4/29/53 ww

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]91

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 College Ck. Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis; STREET ADDRESS (If rural give location) 23 College Ck. Terrace

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) (Last) Hall

4. DATE OF DEATH: (Month) April (Day) 20 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 3-1-1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Chesterfield, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles Johnson

14. MOTHER'S MAIDEN NAME: Fannie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: —

17. INFORMANT'S ADDRESS: James Booth - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) [illegible] DUE TO Pneumonia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) [illegible] DUE TO

(c)

Interval Between Onset And Death: 7 days

490X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 14, 1953, to April 20, 1953, that I last saw the deceased alive on April 20, 1953, and that death occurred at 10:00 AM from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) ADDRESS 116 - 6th St Glen Burnie DATE SIGNED 4/22/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4-23-53 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 4/22/53 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR William Reese, II ADDRESS 108 N. Washington St. Annapolis, Md.

Ink.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03692

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Alk — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
LENGTH OF STAY (In this place) 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS MHC.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 837 Eutaw St.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) — (Last) HALL
4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1953

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): wid
8. DATE OF BIRTH: 1896
9. AGE last birthday: 57 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: MHC records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho-pneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congestive heart failure (c) Arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH: 1 I days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Malnutrition

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 27, 1953, to April 7, 1953, that I last saw the deceased alive on April 6, 1953, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas A. Ocasio M.D. ADDRESS: 2nd House of Correction DATE SIGNED: Apr. 7/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4/15/53
NAME OF CEMETERY OR CREMATORY: Mt. Auburn cem.
LOCATION (City, town, or county) (State): Balto. City

DATE REC'D BY LOCAL REG.: 4/10/53
REGISTRAR'S SIGNATURE: a w Hedrick
24. FUNERAL DIRECTOR: Walter B. Spriggs
ADDRESS: 134 W. Lanvale St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
LENGTH OF STAY (in this place) 10yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4008 Ritchie Hgwy.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
STREET ADDRESS (If rural give location) 4008 Ritchie Hgwy.

3. NAME OF DECEASED: (Type or Print) (First) Laura (Middle) Drager (Last) Herbst

4. DATE OF DEATH: (Month) April (Day) 6 (Year) 19 53

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: August 20, 1867

9. AGE last birthday: 81 80 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Theodore Herbst 4008 Ritchie Hgwy.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebro-Vascular Accident

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Generalized A.S.C.V.H.D.

DUE TO (c)

Interval Between Onset And Death

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1952, to Sept 5, 1952, that I last saw the deceased alive on Sept 5, 19 52 and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE A. J. Gonce Jr. M.D. (Degree or title) ADDRESS 4016 Ritchie Hwy. Brooklyn 25 Md. DATE SIGNED 4/9/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4/9/1953 — NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery — LOCATION (City, town, or county) (State) Anne Arundel Co., Md.

DATE REC'D BY LOCAL REGISTRAR 4/10/53 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hgwy.

VS. A 15-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03694
Reg. Dist. No. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A-15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville P.O. (Gloston)
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 172 Gloston Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville P.O. (Gloston)
STREET ADDRESS (If rural give location) 172 Gloston

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Ann (Last) Hohwiler

4. DATE OF DEATH: (Month) April (Day) 8 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Nov. 20, 1869

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Car Cleaner (ret)

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R. Co.

11. BIRTHPLACE (State or foreign country): Harmons A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Gaither

14. MOTHER'S MAIDEN NAME: Elizabeth Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-12-3631

17. INFORMANT & ADDRESS: Mrs. Charles Wood - Gloston (Millersville P.O.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
174X Immediate cause	(a) Sarcoma of uterus	+ 2 years
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Synovial sarcoma of left knee	+ 2 y.
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March ..., 1952 to 4/8/53, 19..., that I last saw the deceased alive on 4/7/..., 1953, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gustave K. Fischer M.D. ADDRESS Glen Burnie Md. DATE SIGNED 4/11/53

23. BURIAL, CREMATION, REMOVAL. (Specify) Burial DATE THEREOF April 11, 1953 NAME OF CEMETERY OR CREMATORY Glen Haven LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REGISTRAR April 11, 1953 REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR R. Livingston ADDRESS Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
LENGTH OF STAY (In this place) 8 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Donaldson Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odd
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) (Last) Holland

4. DATE OF DEATH (Month) April (Day) 10 (Year) 1953

5. SEX F.

6. COLOR OR RACE Colored

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify) Widowed

8. DATE OF BIRTH ?

9. AGE last birthday 73? yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Prince Georges Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Holland

14. MOTHER'S MAIDEN NAME Nancy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. No

17. INFORMANT AND ADDRESS Mrs. Elizabeth Holland daughter in law

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senecal arteriosclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

PHYSICAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave A. Reubert M. (Degree or title) Deputy Medical Examiner ADDRESS Glen Burnie Md. DATE SIGNED 4/10/53

PLACE OF BURIAL (Cemetery or Crematory) BURIAL — DATE THEREOF 4/13/53 — NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY — LOCATION (City, town, or county) (State) BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR 4/13 — REGISTRAR'S SIGNATURE L. J. D'Alba

24. FUNERAL DIRECTOR Charles H. Wolfe — ADDRESS Balto. 23, Md. 512 Carroll Ave.

MARGIN RESERVED FOR BINDING. PRINT PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct and specially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]96

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) ELLEN (Middle) JEAN (Last) Ireland

4. DATE OF DEATH: (Month) April (Day) 8 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: Jan 5 1953

9. AGE last birthday: 3 months yrs. — IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank M. Ireland

14. MOTHER'S MAIDEN NAME: Elsie Louise Paddy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Frank M. Ireland, Lothian, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 493X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1, 1953, to 4-8, 1953, that I last saw the deceased alive on 4-7, 1953, and that death occurred at 12:35 m., from the causes and on the date stated above.

SIGNATURE Philip Duncan (DEGREE OR TITLE) MD ADDRESS 212 Prince George — DATE SIGNED 4-8-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 4-9-1953 — NAME OF CEMETERY OR CREMATORY Mt Zion — LOCATION (City, town, or county) (State) Lothian Md

DATE REC'D BY LOCAL REG. April 9, 1953 — REGISTRAR'S SIGNATURE [signature] — **24. FUNERAL DIRECTOR** T A Hardesty & Son — ADDRESS Odenton Md

21 132894 04

RECEIVED
1953
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. ... .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Magothy Beach

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Riverside Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Magothy Beach

STREET ADDRESS (If rural give location): Riverside Drive.

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) E. (Last) Kahr.

4. DATE OF DEATH: (Month) April (Day) 21, (Year) 19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	June 15, 1879	About 73 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Night Watchman	?	Chester Pa	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Daniel H. Kahr.	Mary A. Smith.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Lillian Liersman. Riverside Drive. Magothy Beach. A.A.C

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Congestive Heart Failure — Interval Between Onset And Death: 9 months

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO Myocardial infarction — 9 months

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 20, 1952, to Apr. 21, 1953, that I last saw the deceased alive on April 21 1953, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin, M.D.	Pasadena, Md.	April 21. 1953

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 24 53	Lorraine Park	Windsor Mill Rd Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/23/53	[illegible] M.D.	Austin E. Donovan	3818 Roland ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Annapolis
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A.Co. Gen'l. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
STREET ADDRESS (If rural give location) Hollywood Rd. Box 305 - Rt. 2

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Esther (Last) Klein
4. DATE OF DEATH: (Month) 4 (Day) 21 (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	Nov. 6, 1902	50 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework (at)	Own Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: George Schmeiser
14. MOTHER'S MAIDEN NAME: Augusta Lechleuning

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Unknown	Howard Klein, Severna Park, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

401.0 Immediate cause (a) Acute Fibrinous Pericarditis — Interval Between Onset And Death: 3 days.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 3 days

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19, 1953, to 4-21, 1953, that I last saw the deceased alive on 4-21, 1953, and that death occurred at 8:12 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward L. Beck M.D. — ADDRESS 41 Southgate Ave Annapolis Md. — DATE SIGNED 4-21-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4-24-53 — NAME OF CEMETERY OR CREMATORY Glen Haven — LOCATION (City, town, or county) Glen Burnie — (State) Md.

DATE REC'D BY LOCAL REGISTRAR April, 1953 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR T. K. Leighton — ADDRESS Glen Burnie Md.

Received in U. 4-20-53

VS. A15

RECEIVED
APR 29 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

VS. A-6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Cecil — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton, Route 2
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ferdinand	Joseph	Kraus	April	1	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widower	Aug 23/1893	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker	Truck Farm	Baltimore Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Kraus	Theresa Weigand

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	212-03-4457	William J. Weigand

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.2

Immediate cause (a) Coronary Thrombosis — Hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

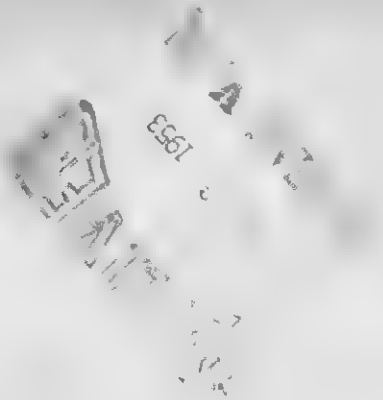
TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3/21/53 19..... to 4/1/53 19....., that I last saw the deceased alive on 3/21/53 19....., and that death occurred at 7 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John C. Alexander M.D.		Cecil Avenue	4/1/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 4-53	New Cathedral	Old Frederick Rd Baltimore Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/2/53	Z. J. DeAlba	Bernard A. Frey	Elkton, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A.Co — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (In this place) 30
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A.A.Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural give location) 775 WARDOUR DRIVE

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) KATHERINE (Last) LEE
4. DATE OF DEATH: (Month) APRIL (Day) 17 (Year) 1953
5. SEX FEMALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW
8. DATE OF BIRTH Aug 11, 1877
9. AGE Last birthday 75 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME CHARLES EBBERTS
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT J. AUBREY LEE ANNAPOLIS MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Vascular Accident — 5 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic CVD — 10 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1952, to 4/17, 1953, that I last saw the deceased alive on 4/17/, 1953, and that death occurred at 10 30 P m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

Frank M. Shipley MD Annapolis 4/18/53

23. BURIAL, CREMATION REMOVAL (Specify) Buried — DATE THEREOF 4-20-53 — NAME OF CEMETERY OR CREMATORY Woodlawn — LOCATION (City, town, or county) (State) Woodlawn Md

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE Livingston Wallace, M.D. — 24. FUNERAL DIRECTOR Hopp & B.M. Walters — ADDRESS Pratt & Stricker Sts

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Items 8,9 FilmG153/4/16/53 mhw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
STREET ADDRESS (If rural give location) 6036 Bell Grove Road

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) (Last) Limburger

4. DATE OF DEATH: (Month) 4 (Day) 6 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 9/15/1908 1891?

9. AGE last birthday: 45?? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) Chronic Myocarditis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO

(c)

Interval Between Onset And Death: unknown

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decubitus Ulcers

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/ ,19 53, to 4/6/ , 19 53 that I last saw the deceased alive on 4/6/ , 19 53 and that death occurred at 6:55 a.m, from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold N. Eichert, M.D.

ADDRESS Crownsville State Hospital

DATE SIGNED 4/6/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 4/9/53

NAME OF CEMETERY OR CREMATORY Mt Auburn Cem

LOCATION (City, town, or county) (State) Balto Md

DATE RECD BY LOCAL REGISTRAR 4-7-53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Isaiah L Brown Son

ADDRESS 1048 W Montgomery St

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Md.
LENGTH OF STAY (in this place) 3 yrs. 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Baltimore City
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1518 E. Eager Street

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Robert (Last) Littlejohn

4. DATE OF DEATH: (Month) 4 (Day) 5 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 8/9/12

9. AGE last birthday: 40 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Fleming Littlejohn

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW II

16. SOCIAL SECURITY No.: - - - - - -

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) C25X General Paresis — Interval Between Onset And Death: Unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Syphilis — About 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - - - -

19b. MAJOR FINDINGS OF OPERATION - - - - -

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE - - - -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - -

(CITY OR TOWN) - - - - (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? - - - - - - - - - -

22. I hereby certify that I attended the deceased from 2/1, 19 53, to 4/5, 19 53 that I last saw the deceased alive on 4/5, 19 53 and that death occurred at 7:21 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D. — ADDRESS Crownsville, Md. — DATE SIGNED 4/5/53

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 4-29-53 — NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. — LOCATION (City, town, or county) (State) Crownsville, Md.

DATE REC'D BY LOCAL REGISTRAR 4-28-53 — REGISTRAR'S SIGNATURE K. M. Joyce — 24. FUNERAL DIRECTOR Arnold H. Eichert, M.D. — ADDRESS Crownsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MAY 1 1933

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn 25; LENGTH OF STAY (In this place) 12 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 1247 - Belgrove Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) Olivia (Last) Lyches.

4. DATE OF DEATH: (Month) April (Day) 19 (Year) 1953

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow.

8. DATE OF BIRTH: 9/25/68

9. AGE last birthday: 84 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Mobray

14. MOTHER'S MAIDEN NAME: Sarah Swann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None.

17. INFORMANT AND ADDRESS: Mrs. P. Dore (daughter).

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Cerebral hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senile arteriosclerosis	?
	(c) Hypertension	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) — INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE (Degree or title): Eustace H. Fowler M.D., Deputy Medical Examiner. ADDRESS: Glen Burnie, Md. DATE SIGNED: 4/19/53

23. BURIAL, CREMATION REMOVAL (Specify): — DATE THEREOF: 4-22-53 NAME OF CEMETERY OR CREMATORY: Cedar Hill LOCATION (City, town, or county): Baltimore (State)

DATE REC'D BY LOCAL REG.: 4/20/53 REGISTRAR'S SIGNATURE: Mrs. Hedwig [illegible] 24. FUNERAL DIRECTOR: Francis T. McCleary ADDRESS: Dun — 130 E. Fort Ave.

VS. A15A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A161 8-51

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 323 1st Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

STREET ADDRESS (If rural, give location): 323 1st Street

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) (Last) Mayhew

4. DATE OF DEATH: (Month) April (Day) 3, (Year) 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 25, 1863

9. AGE last birthday: 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): St. Mary's County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ---

(If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs John Jones 314 West Street Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Instant

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerosis Heart Disease — Several Yrs

DUE TO

(c) Generalized Arteriosclerosis — Several Yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 19 52, to April 3, 19 53, that I last saw the deceased alive on April 3, 19 53, and that death occurred at 1:30 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

George C Basil M. D. Annapolis 4-4-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 4-6-53

NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: April 6, 1953

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Md.

RECEIVED
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53 05

CERTIFICATE OF DEATH

Reg. Dist. No. . .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Maryland
LENGTH OF STAY (in this place) 9 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1801 Etting Street

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) (Last) Mitchell

4. DATE OF DEATH: (Month) 4 (Day) 15 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11/19/10

9. AGE Last birthday: 42 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Dry Dock

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ben Mitchell

14. MOTHER'S MAIDEN NAME: Fanny Johnson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) — — — —

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 4 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated with central ~~nervous system syphilis~~ Known to us since 10/13/36

19a. DATE OF OPERATION: — — — — — —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — — — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/1 ..., 19 53, to 4/15 ..., 19 53, that I last saw the deceased alive on 4/15 ., 19 53, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Sibert M.D. ADDRESS Crownsville, Md. DATE SIGNED 4/15/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4 - 19-1953 — NAME OF CEMETERY OR CREMATORY Mt. Calvary — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR April 18 1953 — REGISTRAR'S SIGNATURE R.W.S.

24. FUNERAL DIRECTOR Arlington S. Phillips — ADDRESS 1808 N. Monroe St.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LAUREL
LENGTH OF STAY (in this place): 3 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: DISTRICT TRAINING SCHOOL LAUREL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: DISTRICT OF COLUMBIA — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WASHINGTON D.C.
STREET ADDRESS (If rural, give location): 1232 POTOMAC STREET N.W.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) LEWIS (Last) MOORELAND

4. DATE OF DEATH: (Month) 4 (Day) 11 (Year) 1953

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: 1/31.1936

9. AGE last birthday: 17 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INMATE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EUGENE MOORELAND

14. MOTHER'S MAIDEN NAME: LOUISE WEEKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: REC. D.T.S. STAFF LAUREL MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) PNEUMONIA BRONCHO . Bilateral	1 WEEK
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) MALNUTRITION	LIFE
	(c) MENTAL DEFICIENCY UNDETERMINED IDIOT LEVEL	LIFE

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. SPASTIC CEREBRAL AGENESIS — LIFE

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/16/51, 19..., to 4/11..., 1953., that I last saw the deceased alive on 4/10/53, 19..., and that death occurred at 12:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Medical Officer D.T.S. Laurel, Md.

ADDRESS:

DATE SIGNED: 4/11/1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Apr 14 53 — NAME OF CEMETERY OR CREMATORY: Washington Natl Cemetery — LOCATION (City, town, or county) (State): Prince Geo County Md

DATE REC'D BY LOCAL REG.: April 11-53

REGISTRAR'S SIGNATURE: Clara Hadley

24. FUNERAL DIRECTOR: W W Chambers Co — ADDRESS: Wash. D.C.

VS-AT

RECEIVED
MAY 5 1953
BUREAU V. S

69427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS M H C.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE BALTO. COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md.
STREET ADDRESS (If rural, give location) 941 Boyd St.

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) H. (Last) MORGAN
4. DATE OF DEATH: (Month) April (Day) 16 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 1913
9. AGE last birthday: 39 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook.
10b. KIND OF BUSINESS OR INDUSTRY: Mechanic.
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Rosie Morgan.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: M H C Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremic Coma. — 6 mo.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic glomerular Nephritis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 26, 1952 to Apr 16, 1953, that I last saw the deceased alive on Apr 15, 1953, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

SIGNATURE: John A Clark (Degree or title) M.D. — ADDRESS M H C. Jessup Md — DATE SIGNED Apr. 16 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 4/19/53 — NAME OF CEMETERY OR CREMATORY Kent County Cemet. — LOCATION (City, town, or county) Maryland (State)

DATE REC'D BY LOCAL REG. 4/17/53 — REGISTRAR'S SIGNATURE A. W. Hedrick M.H.

24. FUNERAL DIRECTOR: A. Halstead — ADDRESS 918 Druid Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13208

CERTIFICATE OF DEATH

Reg. Dist. No. 2 8

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 70 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Guilford Road, Jessups, Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) (Last) Parker

4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1890?

9. AGE last birthday: 63? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min –

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Odd jobs

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country) Georgia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown (If Yes, give war or dates of service) – – –

16. SOCIAL SECURITY No.: – – – – – –

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

Interval Between Onset And Death

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.3

Immediate cause (a) Cardio-vascular Disease — Known to us since 1/30/53

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: – – – – – –

19b. MAJOR FINDINGS OF OPERATION –

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) – – – – – –

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) – – –

(CITY OR TOWN) (COUNTY) (STATE) –

TIME OF INJURY (Month) (Day) (Year) (Hour) – – – m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? –

22. I hereby certify that I attended the deceased from 2/17, 19 53 to 4/10, 19 53, that I last saw the deceased alive on 4/10, 19 53, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

SIGNATURE Arnold H. Eichert (Degree or title) M.D. ADDRESS Crownsville, Md. DATE SIGNED 4/10/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 4/14/53

NAME OF CEMETERY OR CREMATORY University Med School

LOCATION (City, town, or county) (State) Baltimore Md

DATE REC'D BY LOCAL REGISTRAR 4/14/53

REGISTRAR'S SIGNATURE ~~L. J. D...~~ K. M. Joyce

24. FUNERAL DIRECTOR Frances A. Hensley ADDRESS 578 N Biddle St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-5

APR
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 28

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY AA — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crumpville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mercy Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 932 N. Stricker St

3. NAME OF DECEASED: (Type or Print) (First) Dolores (Middle) Maria (Last) Parker

4. DATE OF DEATH: (Month) 4 (Day) 24 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 10/12/49

9. AGE Last birthday: 3 yrs. IF UNDER 1 YEAR: Months / Days / Hours / Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lester Parker

14. MOTHER'S MAIDEN NAME: Mary Williams

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16 SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mary William 932 N. Stricker St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

Immediate cause (a) Bronchopneumonia DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-26-, 1953, to 4-27-, 1953, that I last saw the deceased alive on 4-24-, 1953, and that death occurred at 10:53 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4/28/53 NAME OF CEMETERY OR CREMATORY Mt. Auburn LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REGISTRAR 4/27/53 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR [signature] ADDRESS

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 179 S Cherry Grove Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 179 S. Cherry Grove Ave; STREET ADDRESS (If rural give location) Annapolis, Md.

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) E. (Last) QUINN

4. DATE OF DEATH: (Month) April (Day) 14 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify):

8. DATE OF BIRTH: 8/6/1880

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James T. Small

14. MOTHER'S MAIDEN NAME: Mary Ella Jewell

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT & ADDRESS: Mrs. H. E. Letourneau Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Occlusion — Interval Between Onset And Death: 1 hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Coronary Artery Disease — yr.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURED While at Work ☐ Not While At Work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 1951..., to ...4/14..., 1953..., that I last saw the deceased alive on 4/8, 1953, and that death occurred at ...1...P M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Grant M. Shipley M.D. ADDRESS Annapolis DATE SIGNED 4/14/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 4/16/53; NAME OF CEMETERY OR CREMATORY Cedar Bluff; LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR April 16, 1953; REGISTRAR'S SIGNATURE J. Owen Bowl

24. FUNERAL DIRECTOR John H. Taylor & Sons; ADDRESS Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft Meade Annex — LENGTH OF STAY (in this place) 5 months.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cresston Park Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Ann Arundle
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural, give location) Cresston Park Road

3. NAME OF DECEASED Type or Print: (First) William (Middle) Rufus (Last) Riddle

4. DATE OF DEATH: (Month) April (Day) 17 (Year) 1953

5. SEX: M. — 6. COLOR OR RACE: W. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: 11/7/80 — 9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter. — 10b. KIND OF BUSINESS OR INDUSTRY: Self. — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James P. Riddle — 14. MOTHER'S MAIDEN NAME: Emma Loveless.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: 214-12-7893-A — 17. INFORMANT AND ADDRESS: Donald P. Riddle (Same as #1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151X **Immediate cause** (a) Cancer of stomach — 6 months.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic prostatitis - — 6 .

(c) Old fracture of left femur — 6.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION: — — 19b. MAJOR FINDINGS OF OPERATION: — — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I saw, that I took charge of the remains described above held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence of same by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
Gustave K Faulkenhus. D. Surgery Medical Examiner — Glen Burnie Md. — 4/17/53

DISPOSITION (Burial, Cremation, Removal) (Specify): Burial — DATE THEREOF: 20 April 1953 — NAME OF CEMETERY OR CREMATORY: St Johns Cemetery — LOCATION (City, town, or county): Beltsville — (State): Md.

DATE RECEIVED BY LOCAL REG.: April 19, 1953 — REGISTRAR'S SIGNATURE: Amanda Harper — 24. FUNERAL DIRECTOR: B. Hoards Sons — ADDRESS: Hyattsville, Md.

3668

M

I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PRINT CLEARLY WITH UNFADING INK. Supply every item of information carefully. Type or print in permanent ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Glen Burnie
LENGTH OF STAY (In this place): 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dorsey Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Same — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Same

3. NAME OF DECEASED (Type or Print): (First) Ada (Middle) Flag (Last) Schmuff

4. DATE OF DEATH (Month) (Day) (Year): 4/30/53

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/10/96

9. AGE last birthday: 57 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / M

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Virginia.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Kline

14. MOTHER'S MAIDEN NAME: Anna Kline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: John Schmuff (husband). Dorsey Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — Sudden

Antecedent cause(s) Disease or conditions if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — Over 3 y.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒ X

21. ENTER AL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22 I saw that I took charge of the remains described herein, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence of said Autopsy, Inspection or Inquiry, and I said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐

SIGNATURE: Gustave H. Faucher M.D. (Degree or title): Deputy Medical examiner. ADDRESS: Glen Burnie, Md. DATE SIGNED: 5/1/53

DISPOSITION: Burial — DATE THEREOF: 5/4/53 — NAME OF CEMETERY OR CREMATORY: Woodlawn Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 5/1/53 — REGISTRAR'S SIGNATURE: A. W. Hedrich — J.C.L.

27. FUNERAL DIRECTOR: John J. Bowen & Son — ADDRESS: Ft. Hollins

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1 PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 600 Hammonds Lane

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
STREET ADDRESS (If rural give location) 600 Hammonds Lane

3. NAME OF DECEASED: (Type or Print) (First) Sophie (Middle) E. (Last) Seifert

4. DATE OF DEATH: (Month) April (Day) 18 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: Feb. 7, 1879

9. AGE Last birthday: 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria-Hungary

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Anto Rubezch

14. MOTHER'S MAIDEN NAME: Phillipia ----

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No: none

17. INFORMANT & ADDRESS: John J. Seifert, 600 Hammonds Lane, Linthicum, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cerebral Haemorrhage — 18 days.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arterio - sclerosis & Hypertension — 10 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. ., 19[illegible], to 4/18/53, 19 , that I last saw the deceased alive on 4/18, 1953, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE Alex L. Race — (Degree or title) — ADDRESS 203 W. Maple Rd., Linthicum, Md. — DATE SIGNED 4/21/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4/22/53 — NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery — LOCATION (City, Town, or County) Anne Arundel Co. — (State) Md.

DATE RECD BY LOCAL REGISTRAR 4/23/53 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR — ADDRESS George J. Gonce, 4001 Ritchie Hgwy.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 1340 Bestgate.

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) [illegible] (Last) Simms

4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 7-4-1900

9. AGE last birthday: 52 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Simms

14. MOTHER'S MAIDEN NAME: Julia Ann Ennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Corsina Simms Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterial Hypertension

DUE TO

(c)

Interval Between Onset And Death: 2 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1952, to April 10, 1953, that I last saw the deceased alive on April 10, 1953, and that death occurred at 10:05, from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) MD ADDRESS 110 - Cathedral St. Annapolis DATE SIGNED 4/13/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4-14-53 NAME OF CEMETERY OR CREMATORY Forever Hill LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR April 14, 1953 REGISTRAR'S SIGNATURE [illegible] D.W.

24. FUNERAL DIRECTOR William Reese & Son ADDRESS 108 W. Washington St. Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Anne ARundel MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN) and give nearest town)

LENGTH OF STAY (in this place) 6 Mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne ARundel County Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Anne ARundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Elmo	C	Stallings	4	10	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	White	Single	Jan. 7 1881	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
in attendance - Dr. Retired		Anne ARundel Co.	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Corey Stallings	Emma Seigert Stallings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	214-03-5148A	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
4221 Immediate cause	(a) Cerebral Thrombosis, L. Hemiplegia	6 Wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis C.V. disease.	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 10/16..., 1952, to 4/10..., 1953, that I last saw the deceased alive on 4/8..., 1953 and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Marvin W. Kammons	MD	Annapolis, Md	4/10/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	4/12/53	Galesville Church	Galesville	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/12/53	Edward Collenson	T A Hardesty & Son	Galesville Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 22716

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY a a — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 139 Charles St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 139 Charles St.

3. NAME OF DECEASED: (Type or Print) (First) Evalen (Middle) Jane Dennis (Last) Sterling

4. DATE OF DEATH: (Month) 4 (Day) 9 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: Oct 18th 1865

9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Locomoke City Md.

12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: Henry Clay Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Miss Jeannette P. Sterling Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset And Death 24 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis Generalized
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN ..., 1942, to 4-9 ..., 1953, that I last saw the deceased alive on 4-9 ..., 1953, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) MD — ADDRESS Annapolis Md — DATE SIGNED 4/15/53.

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 4-11-53 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR April 11, 1953 — REGISTRAR'S SIGNATURE B.W. — FUNERAL DIRECTOR John M. Tayla & Sons — ADDRESS Annapolis Md.

VS. 415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 , 19

CERTIFICATE OF DEATH

Reg. Dist. No. 2-5

MARGIN RESERVED FOR BINDING

NOTE: WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 45

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
LENGTH OF STAY (in this place): 20yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4 W. 3rd Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
STREET ADDRESS (If rural give location): 4 W. 3rd Ave.

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Martin (Last) Stickler

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: August 9, 1902

9. AGE last birthday: 50 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt.

10b. KIND OF BUSINESS OR INDUSTRY: Goodyear Tire Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Martin J. Stickler

14. MOTHER'S MAIDEN NAME: Agnes Haid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-07-4845

17. INFORMANT & ADDRESS: Gerard T. Stickler 3034½ Pinewood Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) DUE TO: Cerebral Hemorrhage — 1 hour

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Hypertension, Cardiovascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to April 4, 1953, that I last saw the deceased alive on April 3, 1953, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): Nathan Snyder M.D. — ADDRESS: 1200 St. Paul St. — DATE SIGNED: April 6, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 7, 1953 — NAME OF CEMETERY OR CREMATORY: Holy Cross Cem — LOCATION (City, town, or county) (State): Anne Arundel Co., Md.

DATE REC'D BY LOCAL REGISTRAR: 4-6-53 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce 4001 Ritchie Hgwy

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03718

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and/give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 1750 West St

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Mary (Last) Taylor
4. DATE OF DEATH: (Month) 4 (Day) 12 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: 4-11-1885
9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Prince Georges Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Sonny
14. MOTHER'S MAIDEN NAME: Georganda Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Daniel Taylor-Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Disease — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLAC. OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
(CITY OR TOWN): Annapo.
(COUNTY): A A Co
(STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour)
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: C Hartnett (Degree or Title): MD ADDRESS: Annapolis Md DATE SIGNED: 4/15/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4-15-1953
NAME OF CEMETERY OR CREMATORY: Brewer Hill
LOCATION (City, town, or county): Annapolis
(State): Md.

DATE REC'D BY LOCAL REG. 4/16/53
REGISTRAR'S SIGNATURE: a w Hedrick
24. FUNERAL DIRECTOR: William Riese Jr
ADDRESS: 108 W Washington St. Annapolis Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. Gen. Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Carroll (Middle) Rossiter (Last) Thomas

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify): —
8. DATE OF BIRTH: 9-21-1911
9. AGE last birthday: 41 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Fort George G. Meade
10b. KIND OF BUSINESS OR INDUSTRY: Postal Clerk
11. BIRTHPLACE (State or foreign country): Severn A A Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carroll R. Thomas
14. MOTHER'S MAIDEN NAME: Virginia Clyde Joyce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Gertrude M. Thomas Gambrills Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X
Immediate cause (a) acidosis — Interval Between Onset And Death: 36 hrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) diabetis mellitus (severe) — 10 yrs (?)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/12 ,1953, to 4/15 , 1953, that I last saw the deceased alive on 4/15 , 1953, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
C. Bosmeck M.D. — Annapolis Md — 4/15/53

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify) | DATE THEREOF 4-18-53 | NAME OF CEMETERY OR CREMATORY St. Stephens Cemt. | LOCATION (City, town, or county) Chesterfield A.A.Co. (State) Md.

DATE REC'D BY LOCAL REGISTRAR April 16, 1953 | REGISTRAR'S SIGNATURE C. Bosmeck M.D.

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 '20

CERTIFICATE OF DEATH

Reg. Dist. No. '20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville

LENGTH OF STAY (In this place): 55 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Willow Glenn Farm

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville

STREET ADDRESS (If rural, give location): Willow Glenn Farm

3. NAME OF DECEASED: (First) MYRTLE (Middle) WINONA (Last) TOWNSHEND

4. DATE OF DEATH: (Month) APRIL (Day) 13, (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Dec. 9, 1878	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House wife	own home	Davidsonville Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Daniel Webster Townshend	Martha Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
----	----	-----	Mr. Earl G. Townshend same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
332 X Immediate cause	(a) Cerebral thrombosis	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) hypertension, arteriosclerosis diabetes.	
DUE TO		
626 X	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 19 53, to 4-13, 19 53, that I last saw the deceased alive on 4-13, 19 53, and that death occurred at 5-9 m., from the causes and on the date stated above.

SIGNATURE: Emily H. Wilson (DEGREE OR TITLE) M.D. ADDRESS: Lothian, Md. DATE SIGNED: 4-13-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-15-53	All Hallows Cemetery	Davidsonville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
April 14, 1953	Carrie Smith Recd. 4-15-53	Ben L. Hopping and Son Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]21

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 [illegible]

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harryside
LENGTH OF STAY (in this place) 59 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Ulysses (Middle) Grant (Last) Turner

4. DATE OF DEATH: (Month) (Day) (Year) 4/15/53 19

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Married	10/10/64	33 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Waterman	Crabbing	Baltimore City, Md.	

13. FATHER'S NAME: Vincent Turner

14. MOTHER'S MAIDEN NAME: Frances ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Charles Bast, Shadyside, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
442X Immediate cause	(a) Myocardial Infarction	12 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Congestive heart failure	9 mos.
	DUE TO (c) Arteriosclerotic Cardiovascular renal disease	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

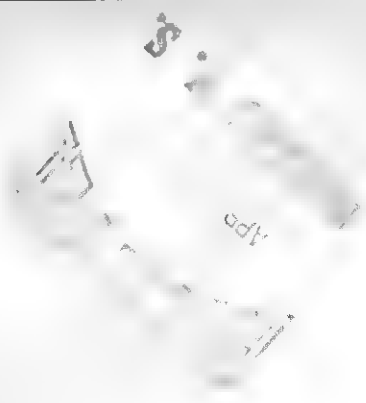
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 6-30, 1953, to 4-15, 1953, that I last saw the deceased alive on 4-15, 1953, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE Louise Linn Grant — (DEGREE OR TITLE) M.D. — ADDRESS Shady Side, Md. — DATE SIGNED 4.16.53.

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/18/53	Quaker cemetery	Galesville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 17	J. B. Dent	T. A. Hadaway & Son,	Galesville, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: Ft. Geo. G. Meade
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FORT GEORGE G MEADE
LENGTH OF STAY (in this place) 34 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS U S Army Hosp. Ft. Geo. G. Meade, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (16)
STREET ADDRESS (If rural give location) 2001 Garrison Blvd.

3. NAME OF DECEASED: (Type or Print) (First) MARK (Middle) STEPHEN (Last) WAGNER
4. DATE OF DEATH: (Month) APRIL (Day) 13 (Year) 1953
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant
8. DATE OF BIRTH: 12 APRIL 1953
9. AGE last birthday: NEWBORN yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 34 Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ft. George G. Meade, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward B. Wagner
14. MOTHER'S MAIDEN NAME: Claire T. Shuckle
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: MOTHER

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
762.0
Immediate cause (a) Atelectasis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)
Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) (COUNTY) (STATE) —
TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ..., 19..., to ..., 19..., that I last saw the deceased alive on 13 April 1953, and that death occurred at 2250 pm ..., from the causes and on the date stated above.
SIGNATURE Joseph B Shuckle (Degree or title) M.D. ADDRESS Annapolis, Md DATE SIGNED 13/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 15 April 53
NAME OF CEMETERY OR CREMATORY Post Cemetary
LOCATION (City, town, or county) (State) Fort George Meade, Md.
DATE REC'D BY LOCAL REGISTRAR 14 Apr 53
REGISTRAR'S SIGNATURE [illegible] Capt MSC
24. FUNERAL DIRECTOR J.P. SPENCER Capt (Chaplain) ADDRESS Ft Meade, Md.

2043211374

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 53

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY AA Co
CITY (If outside corporte limits, write RURAL OR and give nearest town) TOWN Pt Pleasant-R.D. Glen Burn
LENGTH OF STAY (in this place) 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLENBURNIE
STREET ADDRESS (If rural give location) Pt Pleasant

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) JOHN (Last) WANKO

4. DATE OF DEATH: (Month) 4 (Day) 21 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: JUNE 4 1874

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): GLASS WORKER

10b. KIND OF BUSINESS OR INDUSTRY: MESHENE OPERATOR

11. BIRTHPLACE (State or foreign country): PITTSBURG PA

12. CITIZEN OF WHAT COUNTRY? YES

13. FATHER'S NAME: ANDREW WANKO

14. MOTHER'S MAIDEN NAME: ANNA TALLION

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No: none

17. INFORMANT & ADDRESS: GEORGE WANKO 1217 JAMES ST. BALTO MD

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
154 Immediate cause	(a) Carcinoma of rectum	+ 2 Y
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Mitral Insufficiency	+ 5 Y.
	DUE TO (c) Hemorrhage from rectum	6 months
II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1951, to April 21, 1953, that I last saw the deceased alive on 4/20, 1953 and that death occurred at 10.40 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Gustave A Paulsen MD ADDRESS Glen Burnie Md. DATE SIGNED 4/21/53.

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | DATE THEREOF 4/24/53 | NAME OF CEMETERY OR CREMATORY MT OLIVET CEM | LOCATION (City, town, or county) (State) FREDRICK RD

DATE REC'D BY LOCAL REGISTRAR 4/24/53 | REGISTRAR'S SIGNATURE A.W. Hedrick

24. FUNERAL DIRECTOR Chas P. Towell ADDRESS 4411 Windsor Mill R.D.

Done

Dr. Gustave H Faubert
5 First ave south East
Glen Burnie. MD, Phone 340

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md. — LENGTH OF STAY (In this place)
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A. A.
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md
   STREET ADDRESS (If rural, give location) 26 East St.

3. NAME OF DECEASED (Type or Print): (First) Wilmer (Middle) C. (Last) Watson

4. DATE OF DEATH: (Month) April (Day) 10 (Year) 1953

5. SEX: M.

6. COLOR OR RACE: W.

7. ~~SINGLE~~, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~. (Specify) Single

8. DATE OF BIRTH: 12/13/1899

9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk, A. H. Co.

10b. KIND OF BUSINESS OR INDUSTRY: Public Works

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Malcolm Watson

14. MOTHER'S MAIDEN NAME: Carrie E. Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. James T. Smith 26 East St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY garage. (CITY OR TOWN) Annapolis (COUNTY) Anne (STATE) Md.

TIME OF INJURY (Month) 4 (Day) 10 (Year) 53 (Hour) m.

INJURY OCCURRED While at work ☑ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ✓, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE (Degree or title) MD ADDRESS DATE SIGNED 4/11/53

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — DATE THEREOF 4/13/53 — NAME OF CEMETERY OR CREMATORY St. Anne's — LOCATION (City, town, or county) Annapolis (State) MD.

DATE REC'D BY LOCAL REG. April 11, 1953 — REGISTRAR'S SIGNATURE Bill

24. FUNERAL DIRECTOR John M. Taylor & Sons — ADDRESS Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2725

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY ANN ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place): 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ANNE ARUNDEL GEN

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: HERALD HARBOR
STREET ADDRESS (If rural give location): ANNAPOLIS MD.

3. NAME OF DECEASED: (First) JOHN (Middle) T. (Last) WEAVER
4. DATE OF DEATH: (Month) 4 (Day) 14 (Year) 1953
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: 11/13/1875
9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): RET. FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MONTICELLO, ARK
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES WEAVER
14. MOTHER'S MAIDEN NAME: SARAH E
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) S. AMER.
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: MRS. LETHA SENDIAK, ALEXANDRIA, VIRGINIA

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42...1

Immediate cause (a) DUE TO: Coronary occlusion

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: arteriosclerotic coronary disease

(c) & Gen. arteriosclerosis

Interval Between Onset And Death: 1 hr.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1940, to Apr. 14, 1953, that I last saw the deceased alive on Apr 13, 1953, and that death occurred at 12:55 PM from the causes and on the date stated above.

SIGNATURE (Degree or title): J. Bozeman M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 4/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: APR. 17, 53 — NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL — LOCATION (City, town, or county) (State): FORT MYER VA.

DATE REC'D BY LOCAL REGISTRAR: April 14, 1953 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: W. W. CHAMBERS CO. — ADDRESS: 1400 CHAMPLAIN WASHINGTON DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]26

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY aa — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Friendship
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Chas (Middle) Edward (Last) Wells

4. DATE OF DEATH: (Month) 4 (Day) 8 (Year) 1953

5. SEX: M — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Mar — 8. DATE OF BIRTH: Feb 11 1894 — 9. AGE last birthday: 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farm Laborer. — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Wells — 14. MOTHER'S MAIDEN NAME: Louisa Elton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) — 16. SOCIAL SECURITY No.: 219-16-1905 — 17. INFORMANT & ADDRESS: Eugenia Wells Friendship Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary embolism — Interval Between Onset And Death: 2 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Fall Sudden Death — 3 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hardening of arteries

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19..., to ..., 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at 2 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H. Edward Owen Md

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4-11-53 — NAME OF CEMETERY OR CREMATORY Carters Chapel — LOCATION (City, town, or county) Hall — (State) Md

DATE REC'D BY LOCAL REGISTRAR 4-10-53 — REGISTRAR'S SIGNATURE H. W. Ware — 24. FUNERAL DIRECTOR — ADDRESS

P. E. Sewell Bruce Fred Md

D. B. Dent Churchton Md.

COPY SENT TO ..

..TE 4/15/53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03727

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY a. a. MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Linthicum
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 105 E. Maple Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE COUNTY a. a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Lillian (Middle) Matilda (Last) YEAGER
4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1953

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec. 2. 1899
9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius Perch
14. MOTHER'S MAIDEN NAME: Adelaide Hucksoll
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No.
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Wm Yeager YEAGER (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
443X
Immediate cause (a) Cardio-Vascular Disease — Interval Between Onset and Death: 8 days.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Hypertension — 1 yr.
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1949, to 4/11, 1953, that I last saw the deceased alive on 4/11, 1953, and that death occurred at 2:30 P.m., from the causes and on the date stated above.
SIGNATURE Chas. A. Ball Jr. (DEGREE OR TITLE) M.D. ADDRESS Linthicum DATE SIGNED 4/11/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 4-14-53
NAME OF CEMETERY OR CREMATORY London Park
LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REG. 4/13/53
REGISTRAR'S SIGNATURE a W Hudnis
24. FUNERAL DIRECTOR Fred A. Cole ADDRESS 1913 W. Balto. St.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03728

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY AA — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 1653 N. Appleton St.

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) E. (Last) Young

4. DATE OF DEATH: (Month) 4 (Day) 25 (Year) 1953

5. SEX: M

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Write)? Widower

8. DATE OF BIRTH: June 22, 1863

9. AGE last birthday: 90 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, (Do not use retired) Fireman

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (State or foreign country): Mancock Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] Young

14. MOTHER'S MAIDEN NAME: Catherine Poulson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT'S ADDRESS: Mrs. Ida Poulson 1653 N. Appleton St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause — (a) DUE TO: Senile cardiovascular arteriosclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) DUE TO: age

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23- 1953, to 4-25- 1953, that I last saw the deceased alive on 4-25- 1953., and that death occurred at 6:45 A.M.; from the causes and on the date stated above.

SIGNATURE (Degree or title) Arnold H. Eichert M.D. — ADDRESS Crownsville State Hosp. — DATE SIGNED 4-25-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF April 28 1953 — NAME OF CEMETERY OR CREMATORY Mt. Auburn — LOCATION (City, town, or county) Baltimore, Md. — (State)

DATE REC'D BY LOCAL REGISTRAR 4/28/53 — REGISTRAR'S SIGNATURE a w Hedrick — 24. NAME AND ADDRESS OF FUNERAL DIRECTOR Wm. E. Young Funeral Home 1631 Druid Hill Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15